Submit this document to:
Crime Victims Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP TERMINATION REPORT: FORM VI

This form *must* be submitted within 60 days of the client's last session and you are no longer conducting treatment. Include a *complete description* of the client's diagnosis at the time of termination. This information will assist the CVCP should the client submit a reopening application at a later date.

Bill Procedure Code 0127C For This Report.

Victim's Name		Cvcp Claim Number
Family Member's Name (if counseling is for a family member of a sexual assault or homicide victim)		Date treatment began
Time Period this Report Covers (*from* month/day/year *to* month/day/year)		Date Form Completed
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) Date of last session: .

2) Diagnosis at the time client stopped treatment:

Turn page to continue

3) Reason for termination ***(check all that apply):***

- ☐ Current goals achieved
- ☐ Client choice to terminate treatment
- ☐ Therapist choice to terminate treatment
- ☐ Parent/guardian choice to terminate treatment
- ☐ Client relocated
- ☐ Client unavailable
- ☐ Client referred to other services
- ☐ Other

4) At this point in time, do you believe there is any permanent loss in functioning as a result of the crime injury? If yes, please describe symptoms based on diagnostic criteria for a DSM diagnosis.